OAH Docket No. 11-0900-15230-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of the Involuntary Discharge/Transfer of M.W., Petitioner, by Nile Health Care Center, now known as Providence Place, Respondent	**FINDINGS OF FACT, CONCLUSIONS AND RECOMMENDATION**

The Minnesota Department of Health ("the Department") initiated this contested case proceeding by issuing a Notice of and Order for Hearing on December 16, 2002. The notice scheduled a hearing in this matter for January 8, 2003, at Nile Health Care Center, 3720 23rd Avenue South, Minneapolis, Minnesota. The hearing was continued to February 10, 2003, at the request of the Respondent, in order to allow time for settlement negotiations.

Jim Dostal, Office of the Ombudsman for Older Minnesotans, Minnesota Board on Aging, 2626 East 82nd Street, Suite 220, Bloomington, MN 55425, represented the Petitioner, M.W., in this proceeding. Tom Wachlarowicz, R.N., Director of Nursing, Providence Place, 3720 – 23rd Avenue South, Minneapolis, Minnesota 55407, represented the Respondent, Nile Health Care Center, now known as Providence Place. Neither party was represented by an attorney. The record closed on February 14, 2003, when the Petitioner's post-hearing submission was received.

NOTICE

This Report is a recommendation, not a final decision. The Commissioner of the Minnesota Department of Health will make the final decision after reviewing the hearing record. The Commissioner may adopt, reject or modify these Findings of Fact, Conclusions, and Recommendations. Under Minnesota Law,[1] the Commissioner may not make the final decision until after the parties have had access to this Report for at least ten days. During that time, the Commissioner must give each party adversely affected by this Report an opportunity to file objections to the report and to present argument to her. Parties should contact the Office of the Commissioner, Minnesota Department of Health, 400 Golden Rule Building, 85 East 7th Place, St. Paul, Minnesota 55101 (tel. no. 651-215-5806), to find out how to file objections or present argument.

STATEMENT OF THE ISSUE

The issue presented in this contested case proceeding is whether Providence Place may lawfully discharge the Petitioner and transfer him to another facility for any of the following reasons:

(1) Because transfer or discharge is necessary for the Petitioner's welfare, and his needs cannot be met at Providence Place;

(2) Because the safety of individuals at Providence Place is endangered; or

(3) Because the health of individuals at Providence Place is endangered.

Based upon the record in this matter, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. The Petitioner, M.W., is a 50-year-old man who suffered a spinal cord injury in approximately 1977, when he fell from a second story window. He is a C 5-6 incomplete quadriplegic and has severe scoliosis. He uses an electric wheelchair, which he is able to maneuver himself. He suffers from recurrent urinary tract infections and chronic pain syndrome.[2] A diagnosis of Personality Disorder has recently been made.[3] The Petitioner does not suffer from dementia or cognitive impairment.[4]

2. The Petitioner is able to use his hands to feed himself. He also is able to write by placing the pen between his index and next finger. He is able to do many activities of daily living with set-up assistance and can transfer out of his bed into his wheelchair without any physical assistance. He has sufficient strength to open doors, open locked drawers, dial the telephone, and write letters.[5]

3. The Petitioner was admitted to Providence Place on September 20, 2002.[6] Prior to his admission to Providence Place, he had resided at Infinia Healthcare Center in Willmar, Minnesota. Before living at Infinia, he had lived in an apartment with the assistance of others.[7] Staff at Providence Place was not made aware of the Petitioner's behavioral issues prior to his admission. If Providence Place had known of these issues, he would not have been admitted.[8]

4. At the time of his admission to Providence Place, the Petitioner had chronic open wounds on his back, left groin, and left knee that require care such as the application of dressings and ointments/medications and other protective skin care. The back wound is a basal cell carcinoma. These wounds have continued to require care during the Petitioner's stay at Providence Place.[9]

5. The Petitioner has a history of methicillin-resistant Staphylococcus aureus ("MRSA") and/or vancomycin-resistant enterococcus ("VRE"). These infections involve microorganisms that are resistant to multidrug treatments.[10] Potential modes of transmission of multidrug-resistant bacteria include transmission from one patient to another by hands of personnel or patients; transmission from environmental surfaces by direct contact or by hands of personnel; and transmission from direct contact with contaminated surfaces.[11] The Petitioner was hospitalized for approximately 110 days during 1994 with a MRSA or a VRE infection.[12] There is no indication, however, in the Petitioner's medical records or other records submitted by Providence Place that the Petitioner currently is infected with MRSA or VRE. In fact, cultures taken in December were negative for MRSA and clostridium difficile toxin.[13]

6. The Petitioner has had difficulty getting along with his roommates at Providence Place. Within fourteen days of his admission, the Petitioner had transferred to three different rooms.[14]

7. According to the Petitioner's care plan and his physician's orders, Providence Place staff are to turn the Petitioner during particular intervals during the night, apply medication and change the dressing on his wounds with a specified frequency, and manually stimulate/evacuate the Petitioner's bowel every other day.[15]

8. Staff at Providence Place have entered into agreements with the Petitioner establishing times to turn him at night, change his wound dressings, and conduct his bowel program. The Petitioner frequently refuses these cares or is not present in his room at the agreed-upon time for the treatments.[16] The Petitioner often refuses to allow the night shift staff to perform his bowel program.[17]

9. The Nurse/Manager in the Petitioner's unit has decided that the best way to observe the Petitioner's wounds and do a qualified assessment is to do it while the Petitioner is lying in bed.[18] The Charge Nurse on 3-North also believes the wound care is best done while the Petitioner is in bed for safety and accessibility.[19] The Petitioner prefers his wound care to be performed while he is sitting in his wheelchair. On numerous occasions, the Petitioner has refused to allow Providence Place staff to perform his wound care even if they approached him multiple times.[20]

10. The Petitioner sometimes refuses baths.[21] He has also refused to be weighed since his admission to the facility, and has frequently refused to allow his vital signs to be taken.[22]

11. On November 22, 2002, the Petitioner was encouraged at a care conference to have his pain reassessed. The Ombudsman was present at the conference and informed the Petitioner of his record of conflicts with the staff. He refused pain consultation and reassessment and reiterated that he did not want a psychologist but instead wanted a priest.[23]

12. The Petitioner has frequently refused medical, psychological, pain, and wound management opportunities. He has refused psychological evaluations,

psychiatric appointments, pain clinics, and other doctor appointments. It has been particularly difficult to get him to see wound doctors. He has set up appointments with clinics and then refused to go.[24] For example, he refused to attend appointments at Hennepin County Medical Center ("HCMC") on November 6, 2002, November 15, 2002, and December 18, 2002.[25] He has, however, attended appointments relating to his wounds at HCMC on October 25, 2002, and at Abbott Northwestern Hospital on December 16 and 19 and January 2, 2003.[26]

13. The Petitioner has made death threats and other threats of physical harm to Providence Place staff and residents on more than one occasion. For example, the Petitioner told staff that "when I'm out I'm going to get a gun and come back and shoot you"; called one staff member a "fucking nigger" and said that he was "going to blow [his] fucking brains out"; threatened to "blow [a nurse's] head off"; said that he would ask his cousins to "take care of" certain residents in the facility and that the residents and a nurse would "get the shit beat out of them"; and asked a nurse, "How would you feel with a bullet in your head?" He has also threatened to slap staff on several occasions and apparently told a resident that his father was associated with the mafia.[27] He also told a nurse on January 29, 2003, that he had a younger brother in town who would "take care of" her, pointing out that his brother "is usually law abiding but blood is blood."[28] On January 30, 2003, and on February 10, 2003, he threatened to "kick the ass" of another resident.[29]

14. The Petitioner has operated his electric wheelchair at excessive speeds causing his urinary drainage tubing to become tangled in the electric wheelchair wheels, resulting in his urine spilling in public areas on the 1-South nursing unit and by the administrative offices.[30] When staff requests that the Petitioner slow down while using his wheelchair, he uses expletives and refuses.[31]

15. The Petitioner has rammed his electric wheelchair into medication carts and the office door of administrative staff. He also has operated his wheelchair at excessive speeds and in a manner that endangers other residents of Providence Place. Many of these residents are frail and use wheelchairs or walkers. Some have expressed fears of being in the hallways when the Petitioner is out in his wheelchair. One resident, a double amputee, stayed in his room an entire morning because he was afraid that the Petitioner would hit him.[32] On one occasion, the Petitioner struck a Therapeutic Recreation staff person in the leg while operating his wheelchair at excessive speeds.[33] On another occasion, the Petitioner responded, "Fuck you," when asked to slow down as he approached eight to twelve slow-moving and confused residents suffering from Alzheimer's syndrome.[34] He attempted to run into a nurse with his wheelchair on December 26, 2002, recklessly ran his wheelchair between a staff member and another resident on January 2, 2003, and came at another resident with his wheelchair while verbally attacking him about his alleged homosexuality on January 14, 2003.[35] On January 30, 2003, another resident reported that the Petitioner had intentionally tried to run into him and would have hit him if the other resident had not sped up.[36]

16. The Petitioner frequently utters obscenities and racial and sexual epithets when speaking to Providence Place staff and other residents. For example, he has used the terms "nigger," "coconut head," "African monkey," "fucking bitch," "fat fucker," "faggot," and "poo butt homosexual." He has told black staff members that they should "go back to Africa" and has said that they "have fucking tails." On one occasion, he told a resident that she needed to "get her fat ass out of her wheelchair and get a fucking job." On another occasion he posted a large valentine in a public hallway that indicated that a social worker (a male) wanted the Administrator (also a male) to be his lover. On yet another occasion, he informed a member of the administrative staff that he was "nothing but a fat cocksucker."[37] He has told female residents that they are men and "should put their pricks in [his] hand." His chart contains documentation of numerous incidents of yelling and swearing at staff and other residents.[38] As noted in Finding No. 24 below, at least one resident has responded angrily to the Petitioner's verbal abuse and struck the Petitioner.

17. On December 10, 2002, the Petitioner went to Hennepin County Medical Center ("HCMC") for a pain evaluation and a psychiatric evaluation in accordance with physician orders. Nursing staff at Providence Place told HCMC that the psychiatric evaluation was sought because the Petitioner was verbally abusive to other clients and staff, he had been non-compliance with his treatments, and his behavior had worsened during the prior week. The Petitioner was diagnosed with adjustment disorder – mixed emotions/conduct. HCMC found that the Petitioner was not an imminent risk to himself or others and had no active illness at present, but could perhaps use therapy for dealing with chronic illness. He was discharged back to Providence Place.[39]

18. On December 11, 2002, Providence Place notified the Minnesota Department of Health, Facility and Provider Compliance Division, of the Petitioner's verbal abuse of other residents and staff, and of his refusal of treatments and cares. The Division indicated that Providence Place could issue a 30-day notice of discharge.[40]

19. On December 11, 2002, Dr. Eric Anderson was notified of the Petitioner's pattern of behavior towards other residents and staff and his continued refusal of pain and psychological evaluation. Dr. Anderson gave a verbal order for discharge of the Petitioner with medication to an available facility. Ex. 2.

20. At one time, the Petitioner requested a transfer to another facility. Ex. 3 (entry for Jan. 29, 2003); notice of discharge.

21. A Notification of Transfer or Discharge was issued to the Petitioner dated December 11, 2002. The Notification was given to the Petitioner by the Director of Social Services and the Director of Nursing. The notice informed the Petitioner that "Nile Health Care Center will transfer or discharge you to available accepting facility on 1/11/03." The form used permitted Providence Place to check the applicable reasons for the transfer or discharge under federal law. Providence Place checked two bases for the transfer or discharge: (1) the Petitioner has requested a transfer or discharge and (2) it is necessary for the Petitioner's welfare and his needs cannot be met in the

facility. Other possible bases for discharge under federal law, such as the safety of individuals in the facility would be endangered or the health of individuals in the facility would otherwise be endangered, were not checked on the top portion of the form. Although the Petitioner was, in fact, given a full 30-days' notice of the proposed transfer or discharge, the next section of the form contained check marks indicating that the 30-day notice period could be shortened where the safety of individuals in the facility would be endangered, the health of individuals in the facility would otherwise be endangered, and the resident's urgent medical needs require immediate transfer or discharge. Ex. 2; Attachment to Notice of and Order for Hearing.

22. By letter dated December 12, 2002, the Petitioner appealed the discharge notice and requested a hearing.

23. The Notice of and Order for Hearing initiating this contested case proceeding was issued on or about December 16, 2002. The December 11, 2002, Notification of Transfer or Discharge and the December 12, 2002, notice of appeal were attached to the Notice of and Order for Hearing.

24. On December 24, 2002, the Petitioner alleged that another resident had struck him in the head after an altercation in the smoking room. This altercation was precipitated by the Petitioner calling the other resident a "nigger" and a "motherfucker."[41]

25. On approximately December 27, 2002, the Petitioner took a weekend leave from the facility, purportedly to visit family members. He refused to divulge the address where he would be. The staff later discovered a Motel 6 receipt in the Petitioner's room showing that he had spent the weekend there.[42]

26. On January 3, 2003, the Petitioner stated, "I'm going to pack grenades or maybe a handgun. Then I'll throw the grenades at them or maybe I'll just shoot them. I'm gonna have to start packing a gun and take care of this shit." Providence Place called Minneapolis Police on January 3, 2003, regarding the threats to staff and residents regarding the use of a handgun to shoot people. The police did not remove the Petitioner because they determined that he had no weapon and did not pose an imminent threat.[43]

27. On January 3, 2003, based upon a telephone order from Dr. Eric Anderson, the Petitioner was placed on a 72-hour hold at HCMC due to physical threats to staff and other residents, uncontrolled behavior, and potential for self-injurious behavior. In addition, based upon Dr. Anderson's order, the Petitioner's room was searched for potential weapons and the police were notified of his violent behavior. Narcotics were discovered in his room during the search.[44]

28. The Petitioner's Plan of Care was revised on January 3, 2003. The care conference was attended by the social worker (Emmanuel Woode), the Director of Nursing (Tom Wachlarowicz), a registered nurse (Kay Wager), a licensed practical nurse (Kimberly Rause), and the Petitioner, who disagreed with the revised Plan of

Care and refused to sign the conference summary sheet. The revised plan noted the Petitioner's history of MRSA and VRE and stated that the Petitioner "tampers with closed drainage system and spills urine on floors in private and communal areas of facility" and "purposefully and willfully dumps urine into bed and on clothing." The Plan of Care, as revised, states that staff would empty the Petitioner's urostomy bag at end of their shift or during their shift, if necessary. The Plan of Care was revised to state that the Petitioner would be restricted to his room and the smoking room if further episodes of tampering occurred. The Plan of Care also was revised to indicate that further episodes of spilling urine in private or communal areas or visiting other units or offices will result in loss of battery power for his wheelchair. In addition, the Plan of Care indicated that the Petitioner would only use the 3N elevator and that administrative or social service staff would come to the Petitioner's floor if he sought their assistance.[45]

29. Revisions to the Petitioner's Plan of Care on January 3, 2003, also noted that the Petitioner has been verbally abusive to staff and other residents and uses profanity, racial epithets, verbal threats, and intimidation and expressed goals that the Petitioner would express emotions in a manner that is not harmful to others and would not be harmed or harm others. The Plan of Care was revised to set forth a plan of approach under which staff would respond calmly and politely at all times; intervene immediately in altercations with other residents by separating the parties; inform the Petitioner that verbal aggression is not acceptable and speak with him at a later time when he is calmer; give the Petitioner an opportunity to express frustrations in an appropriate way; provide emotional support; and offer psychological services. The revised Plan of Care noted that the Petitioner has made verbal threats of harm to other residents and staff and has refused psychiatric intervention. The plan of approach to this problem as stated in the revised plan was to treat all threats seriously and call 911 when necessary. The revised Plan of Care also noted that the Petitioner had been observed using his power wheelchair to express frustration by ramming into the medication cart or other objects and threatening to run over others. The stated goal was that the Petitioner would not injure himself or others or destroy property and would express anger in an acceptable way. The plan of approach to this problem was to tell the Petitioner to stop, ask what he is angry about, try to problem-solve, and advise the Petitioner that, if the behavior continues, he may not be able to use the power wheelchair for a period of time unless he can do so safely.[46]

30. Other revisions to the Plan of Care on January 3, 2003, noted that the Petitioner had at times been resistant, uncooperative and manipulative with cares (particularly his wound treatment and medications) and stated as a plan of approach that the Petitioner would be informed that current orders would be given as ordered unless changed by physician or refused by the Petitioner, the Petitioner's refusals would be documented, the Petitioner would be informed of potential consequences of actions, and that two staff persons would perform cares. Finally, the Plan of Care as revised noted that the Petitioner had expressed dissatisfaction with his placement at Providence Place, his behavior would be more appropriate for a facility with a behavior unit, and he wanted to be transferred to another primary physician. As a plan of approach, the revised Plan of Care stated that the Long Term Care Advocacy Center ombudsman

would work with the Petitioner as a liaison with the facility, the facility would follow up on the Petitioner's grievances, and community options and facilities with behavior units would be explored, and physicians who accept the Petitioner's insurance would be determined and contacted (or the Petitioner would be given a list). In connection with the Petitioner's behavioral problems, the Plan of Care notes that, on November 22, 2002, the Petitioner met with the ombudsman and that the Petitioner refused the options offered to him of a pain reassessment, placement in another facility, and a psychologist. In addition, to deal with the Petitioner's behaviors, staff would accompany him to all destinations to observe his behavior.[47]

31. The Petitioner has failed to cooperate with his revised Plan of Care.[48]

32. On January 7, 2003, after he threatened staff and other residents, the Petitioner was again placed on a 72-hour hold and sent to Abbott Northwestern Hospital for a psychological consultation based upon a telephone order of Dr. Anderson. The Petitioner was returned to Providence Place on January 14, 2003. He was placed in a private room as an intervention.[49]

33. On January 20, 2003, the Petitioner called a pharmaceutical supplier, pretended he was a nurse calling for the Providence Place Director of Nursing, and asked that they send his narcotics by cab as soon as possible. The Petitioner was out of control with anger that day, racing up and down the hall in his wheelchair and one and off the elevator more than six times, going from station to station with complaints.[50]

34. On January 29, 2003, the Petitioner emptied his urostomy bag into his bed.[51] On January 30, 2003, the Petitioner allowed his urostomy bag to overflow in areas of the 3-North nursing unit, the north elevator, the 1-North nursing unit, and the carpeted area on 1-South by the nursing home's administrative offices.[52] Later that day, the Petitioner's bed was saturated with urine. It appeared to staff that the Petitioner had emptied his urostomy bag directly into his bed. On February 5, 2003, the Petitioner again took apart his urostomy bag and spilled urine all over himself and his bed. On at least one of these occasions, it appeared to staff that the Petitioner had used a pen or pencil to perforate his urostomy bag causing it to leak urine.[53]

35. On January 29, 2003, the Petitioner was sent to Abbott Northwestern for a psychological evaluation due to his out-of-control behaviors and threats, based on a telephone order of Dr. Anderson. The hospital's notes indicate that the Petitioner "had been threatening to throw footballs at people's heads and had been running people over with wheelchair." Abbott Northwestern Hospital returned the Petitioner to Providence Place later that day, with an instruction that he continue on the same medications.[54]

36. The Providence Place social services staff has met with and counseled the Petitioner on several occasions (October 9 and 17, November 8 and 12, December 10, January 2, 6, 17, 24, and 27) about his complaints, behaviors, and verbal abuse, and has attempted to look for alternative residential opportunities for the Petitioner in the community or in other nursing homes. The nursing staff at Providence Place has

attempted to reach agreements with the Petitioner concerning a time schedule for his cares, the operation of his wheelchair, and treatment of staff and residents. These attempts have proven unsuccessful.[55]

37. When the social worker at Providence Place has asked the Petitioner where he would like to transfer, the Petitioner says "no" to places that he mentions. The social worker at Providence Place has contacted several care facilities that specialize in behavior management, including University Good Samaritan, Wallace City View, and Bryn Mawr. All three rejected the Petitioner on the grounds of his multiple behavior issues. The social worker also contacted Lynnhurst Health Care Center, which had openings, but the Petitioner refused to transfer to Lynnhurst. A registered nurse and a licensed practical nurse from Bethel Care Center visited the Petitioner on February 6, 2003. Bethel Care Center specializes in catering to individuals with multiple behavior issues. Bethel indicated just prior to the hearing on February 10, 2003, that it is willing to take the Petitioner if he is discharged from Providence Place.[56]

38. Dr. Eric Anderson, the Medical Director of Providence Place, is the Petitioner's doctor. There is no evidence that Dr. Anderson has documented that the Petitioner is a danger to the health of others or that Providence Place cannot meet the Petitioner's welfare and needs and a discharge is necessary. Dr. Anderson did not testify at the hearing. He did approve the issuance of the discharge notice to the Petitioner.[57]

39. The Notice of and Order for Hearing initially set the hearing for January 8, 2003. On January 7, 2003, Providence Place requested that the hearing be continued approximately four weeks. Accordingly, the hearing was rescheduled for February 10, 2003.

40. At the outset of the hearing, the Petitioner requested a continuance of the hearing in order to review his chart. After some discussion, it was agreed that the start of the hearing would be delayed by at least one hour in order to permit the Petitioner to look at his records. The Petitioner indicated that he was prepared to proceed after the one-hour review. He also withdrew his request to call particular additional witnesses and agreed that the hearing could conclude on February 10, 2003.

41. On February 9, 2003, the Petitioner was overheard threatening to kill another resident of Providence Place. Ex. 3.

42. The Petitioner has not caused actual physical harm to anyone at Providence Place thus far.[58]

43. Three female residents and one male resident at Providence Place are very afraid of the Petitioner and feel that he poses a threat to them. A male resident is afraid to leave his bed because the Petitioner came close to running into him.[59] In addition, a nursing assistant submitted a written memorandum to Providence Place noting that she was afraid for her personal safety and for that of residents and other staff members.[60]

44. These Findings are based on all of the evidence in the record. Citations to portions of the record are not intended to be exclusive references.

45. The Memorandum that follows explains the reasons for these Findings, and, to that extent, the Administrative Law Judge incorporates that Memorandum into these Findings.

46. The Administrative Law Judge adopts as Findings any Conclusions that are more appropriately described as Findings.

Based upon the Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. Both Minnesota and federal law give the Administrative Law Judge authority to conduct this proceeding and to make recommendations to the Commissioner of the Minnesota Department of Health. The law also gives the Commissioner authority to make findings, conclusions, and a final order in this proceeding.[61]

2. The Department gave the parties proper and timely notice of the hearing, and it has also complied with all of the law's substantive and procedural requirements for initiating and proceeding with this administrative contested case proceeding.

3. Providence Place is a "facility" within the meaning of 42 C.F.R. § 483.5 and is therefore subject to the requirements imposed by federal law before discharging or transferring any of its residents.[62]

4. The Petitioner is a resident of Providence Place within the meaning of 42 C.F.R. § 483.12 and is therefore entitled to the rights created by federal law relating to any transfer or discharge by Providence Place.

5. Before discharging one of its residents, Providence Place must notify the resident and a family member or legal representative of its intent to discharge and the reasons for taking that action in writing and in a language and manner that the resident understands.[63] The notice must also include notice of the resident's right to appeal under the state process, the reason for the discharge, the effective date, the location to which the resident will be discharged, and the name, address and telephone number of the state's long term care ombudsman.[64] Federal law further requires Providence Place to provide its residents with the written notice of discharge at least thirty days before doing so.[65] Providence Place substantially complied with these notice requirements.

6. Under Minnesota law, a resident appealing notification of an intended discharge must request a hearing in writing no later than 30 days after receiving written

notice.[66] The Petitioner filed a timely appeal of Providence Place's notice of discharge.[67]

7. Under Minnesota law, Providence Place must prove facts that are required by law to support its discharge of the Petitioner by a preponderance of the evidence.[68]

8. Under federal law, one legal basis for discharging a resident from Providence Place's facility is that the discharge "is necessary for the resident's welfare and the resident's needs cannot be met in the facility."[69] In order to rely on this legal basis for discharging the Petitioner, there must be documentation in the Petitioner's clinical record by the Petitioner's physician of circumstances establishing that discharge is necessary for his welfare and that his needs cannot be met in the facility.[70]

9. No documentation exists in the Petitioner's clinical record by the Petitioner's physician establishing that discharge is necessary for his welfare and that his needs cannot be met in the facility.

10. Providence Place has failed to prove by a preponderance of the evidence that discharge is necessary for the Petitioner's welfare and that his needs cannot be met in the facility.

11. Under federal law, another legal basis for discharging a resident from Providence Place is that the "health of individuals in the facility would otherwise be endangered" or that the "safety of individuals in the facility is endangered."[71] Documentation by a physician is required to establish that the health of individuals in the facility would otherwise be endangered.[72] Documentation by a physician is not required to establish that the safety of individuals in the facility is endangered.[73]

12. No documentation exists in the Petitioner's clinical record by a physician establishing that discharge is necessary because the health of individuals in the facility would otherwise be endangered.

13. Providence Place has failed to prove by a preponderance of the evidence that the Petitioner's discharge is necessary because the health of individuals in the facility would otherwise be endangered.

14. Providence Place has, however, proven by a preponderance of the evidence that the Petitioner's discharge is necessary because the safety of individuals in the facility is endangered.

15. The Memorandum that follows explains the reasons for these Conclusions, and, to that extent, the Administrative Law Judge incorporates that Memorandum into these Conclusions.

16. The Administrative Law Judge adopts as Conclusions any Findings that are more appropriately described as Conclusions.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

The Administrative Law Judge recommends that the Commissioner DENY the Petitioner's appeal and GRANT Providence Place's proposed discharge of the Petitioner and transfer to another facility.

Dated: March 19, 2003

/s/ Barbara L. Neilson
BARBARA L. NEILSON
Administrative Law Judge

Reported: Tape Recorded (three tapes); no transcript prepared.

NOTICE

Under Minnesota law,[74] the Commissioner must serve her final decision upon each party and the Administrative Law Judge by first-class mail.

MEMORANDUM

As the result of amendments to the Social Security Act contained in the Omnibus Budget Reconciliation Act of 1987,[75] a long term care facility that has been certified as a Medicare provider is allowed to discharge a resident only where certain specific circumstances are present and certain statutory due process requirements have been met. The law permits discharge of a resident when the following grounds are present:

> (i) The transfer or discharge is necessary for the resident's welfare and the resident's welfare cannot be met in the facility;
>
> * * *
>
> (iii) The safety of individuals in the facility is endangered;
>
> (iv) The health of individuals in the facility would otherwise be endangered.[76]

The statutory discharge criteria have also been incorporated into the federal regulations that govern operation of Medicare-certified long-term care facilities, such as Providence Place.[77]

The issue in this contested case proceeding is whether Providence Place may proceed with discharging the Petitioner under one or more of these three legal bases. The federal statute and regulations require that the basis for transfer or discharge be documented in the resident's clinical record by the resident's attending physician

whenever discharge is proposed because the resident's needs cannot be met in the facility and that the basis be documented by "a physician" whenever discharge is proposed because the health of individuals in the facility would otherwise be endangered.

Under OAH rules,[78] the party to a contested case proceeding who is proposing that certain action be taken must prove the facts at issue by a preponderance of the evidence unless substantive law provides a different burden or standard. Because Providence Place proposes to discharge the Petitioner from its facility, it bears the burden of proving by a preponderance of the evidence that it has met the legal requirements for discharge.[79]

Although Providence Place failed to check the blanks in the initial section of the notice of discharge form that indicated that discharge was being sought because "the safety of individuals in the facility would be endangered" or "the health of individuals in the facility would otherwise be endangered," Providence Place did check those blanks in the second section of the notice of discharge form, thereby placing the Petitioner on notice that those grounds for discharge were also being relied upon (in addition to the ground that the transfer or discharge was necessary for his welfare and his needs cannot be met in the facility). Providence Place also offered evidence supporting all three grounds throughout the hearing and clarified during the hearing that it was relying upon all three grounds as a basis for the proposed discharge. The Petitioner did not object to the assertion of the three grounds or express any surprise that all three were raised. He had the opportunity to present testimony and evidence on all three issues and in fact provided such testimony and evidence. Accordingly, it is concluded as a threshold matter that the Petitioner's due process rights to adequate notice were not prejudiced, and it is appropriate to consider whether Providence Place established that the Petitioner's discharge is necessary because the health of individuals in the facility is endangered or the safety of individuals in the facility is endangered.[80]

The Ombudsman also argued that the discharge notice is invalid due to the lack of identification of a location to which he would be discharged, as required by 42 CFR § 483.12. The location was not identified because Providence Place had not been able to locate a facility that would accept the Petitioner at the time the Notice was issued and the Petitioner had declined all of the possible options and had not been cooperative in the process of exploring alternatives. Providence Place learned just before the commencement of the hearing that a particular facility had agreed to accept the Petitioner. More than thirty days have elapsed since the date of the hearing, affording the Petitioner ample time to learn about the identified facility. Under these circumstances, it is concluded that the Petitioner has been provided with adequate notice of the identity of the facility to which he will be discharged.

I.

Providence Place Failed to Prove That the Petitioner's Needs Require his Discharge to Another Facility

At the hearing, Providence Place argued that discharge was necessary for the Petitioner's welfare and that his needs could not be met in its facility. Providence Place provided ample documentation by nursing staff and facility administrators that the Petitioner has refused to allow treatment and cares to be given to him. It may be fair to assume that the Petitioner has a medical need for the provision of the particular treatments and cares that have been prescribed for him and that, since he frequently refuses to allow those treatment and cares to be provided by Providence Place staff, Providence Place has failed to meet the Petitioner's needs and a discharge is warranted. But federal law requires that documentation supporting this ground for discharge be made *by the resident's physician*. The Petitioner's physician at the time of the hearing was Dr. Eric Anderson. Although Dr. Anderson approved the issuance of the notice of discharge to the Petitioner and issued telephone orders from time to time that were noted in the Petitioner's clinical record, he did not testify at the hearing or submit any written document in which he states his opinion that Providence Place cannot meet the Petitioner's needs and discharge is necessary for the Petitioner's welfare. He said nothing that would even suggest that the Petitioner's welfare would be better served by transfer to another facility or that Providence Place was unable to meet his medical or behavioral needs. Accordingly, the Administrative Law Judge is compelled to conclude that Providence Place has not shown by a preponderance of the evidence that discharge is warranted under 42 C.F.R. § 12 (a)(2)(i) based on the ground that the Petitioner's needs cannot be met at Providence Place.

II.

Providence Place Did Not Prove that Discharge is Required because the Health of Others is Endangered.

As discussed above, another ground for discharging a resident from a Medicare-certified long-term care facility that is relied upon by Providence Place is that "the health of individuals in the facility is endangered."[81] There is evidence in the record that the Petitioner recklessly or intentionally allowed his urostomy bag to overflow in his room and in areas of the facility where visitors, other residents, and staff might be exposed to his bodily fluids. Because the Petitioner has a history of MRSA or VRE and these types of bacteria potentially may be transmitted by direct contact with contaminated surfaces, Providence Place contends that the Petitioner poses a danger to the health of individuals in the facility.

The difficulty with Providence Place's argument is that the federal law requires that there be documentation by "a physician" (not necessarily the Petitioner's own physician) when discharge is proposed for this reason. There is no documentation by any physician in the records provided by Providence Place that the Petitioner currently is infected with MRSA or VRE. In fact, the records show that recent cultures taken from the Petitioner in December were negative for the presence of MRSA. In addition, Providence Place has not provided any testimony or written documents by any physician supporting the view that the presence of the Petitioner in Providence Place endangers the health of individuals in the facility for any other reason. As a result, the Administrative Law Judge is compelled to conclude that Providence Place has not

shown by a preponderance of the evidence that discharge is warranted under 42 C.F.R. § 12 (a)(2)(iv) based on the ground that the Petitioner's needs cannot be met at Providence Place.

III.

Providence Place Did Prove by a Preponderance that Discharge is Required because the Safety of Others is Endangered.

The record is replete with references to threats of physical violence made by the Petitioner to staff and other residents of Providence Place. It appears that the Petitioner's behaviors have escalated in recent months, with more threats that he will himself harm residents and staff or have others harm them. These threats have been taken sufficiently seriously that staff at Providence Place have called 911, placed the Petitioner on two 72-hour holds, and required the Petitioner to undergo psychiatric evaluation. Staff at Providence Place have also placed the Petitioner in a private room, ordered that he be accompanied in the facility, required that at least two staff members be present when cares are provided to the Petitioner, and tried to limit the Petitioner to certain areas of the facility. The Petitioner's verbal abuse and use of slurs also poses a serious safety concern, as evidenced by the fact that another resident struck the Petitioner on the head after the Petitioner directed a racial epithet at him.

There is also convincing evidence that the Petitioner has almost struck staff and residents with his wheelchair on numerous occasions and actually struck a staff member on one occasion, and that he does not respond to requests by staff and expectations stated in his care plan that he slow down or exercise more caution while traveling the hallways. The Petitioner testified that his wheelchair goes six miles per hour. There is extensive documentation and supporting testimony that the Petitioner has operated his wheelchair in an extremely careless manner in the vicinity of vulnerable and confused residents, has struck one staff member's leg with his wheelchair, and uses his wheelchair to express his rage. Nursing homes have many frail and vulnerable elderly residents who suffer from physical infirmities as well as Alzheimer's Syndrome, dementia, and other disabilities. Providence Place emphasized that it was not made aware of the Petitioner's behavioral problems when it admitted him last September, and would not have admitted the Petitioner had it known of his behavioral issues. Some residents have made staff aware that they are afraid of the Petitioner and one resident is afraid to leave his bed because the Petitioner has come close to running into him. Providence Place has made extensive efforts to assist the Petitioner in exploring alternative nursing facility options or to return to community housing. It has also implemented several measures in an attempt to protect others at the facility from the Petitioner's uncontrolled outbursts.

In an analogous case,[82] an Iowa nursing home proposed to involuntarily discharge a resident who suffered from multiple sclerosis, blindness, and a personality disorder featuring explosive and aggressive outbursts. The administrative law judge determined that the discharge was warranted based on the health, safety, and emotional welfare of the other residents because the resident had "run his wheelchair

into other residents, restrained their freedom of movement, and directed abusive language at both residents and staff members." 567 N.W.2d at 654. The ALJ found that the resident's physically and verbally aggressive behavior toward other residents had increased during the three months prior to the issuance of the discharge notice. The ALJ also emphasized the resident's lack of cooperation with staff and the decreased ability of staff to redirect the resident's aggression. The discharge was affirmed by the Iowa Supreme Court on the grounds that the finding was supported by ample evidence in the record.

The Petitioner has numerous complaints about his care at Providence Place and provided testimony and documents relating to those complaints. He believes that his medications have been stolen by staff and that he has been refused care; accuses staff of waking him up at night and not giving him his medications or providing his wound treatments or bowel program; contends that he is not turned at night when he is supposed to be; asserts that nursing staff members are rude to him; and complains that his rights have been violated. He frequently threatens to call reporters, make reports to the Department of Health or the Department of Justice, call his lawyer, get staff fired or licenses revoked, and close the facility down. He has a number of concerns about the way in which his medication was handled during his weekend leave in December that are not relevant to the issues in this proceeding. This proceeding is not the proper forum to determine whether there have been shortcomings in the Petitioner's care, but rather focuses on whether a proper basis has been shown for discharge or transfer from the facility. In any event, deficiencies in the Petitioner's care would not justify the type of threats and abusive behavior that has been demonstrated in this proceeding.

The Petitioner asserts that he has never harmed anyone with his wheelchair and denies having used epithets or having threatened others with physical harm. This testimony simply is not credible when viewed against the consistent testimony of Providence Place staff members to the contrary and the massive amount of documentation supporting that testimony. Because the Petitioner is able to leave Providence Place and is able to use his hands for a number of activities, the Administrative Law Judge also is not convinced that he physically would be unable to obtain or shoot a gun or otherwise engage in violent conduct or convince others to do so on his behalf.

The Petitioner suffers from chronic pain, and undoubtedly this contributes to his impatience with staff and his poor ability to get along with others. Unfortunately, the Petitioner has resisted efforts to undergo evaluation to see if he can attain more effective pain management and also has refused to obtain psychological or psychiatric help for his behavior and anger management problems. The record demonstrates that the Petitioner has been unwilling to modify his behaviors, despite multiple attempts by staff to intervene and redirect or counsel him, and that his behavior has become unmanageable at Providence Place. Under these circumstances, the facility has shown that discharge is necessary because the safety of individuals in the facility is endangered.

Conclusion

Based upon all of the evidence, the Administrative Law Judge has concluded that Providence Place has established by a preponderance of the evidence that the Petitioner's discharge is necessary because the safety of individuals in the facility is endangered. It is recommended that the Commissioner deny the Petitioner's appeal and grant Providence Place's proposal to discharge him.

B.L.N.

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[1] Minn. Stat. § 14.61 (2002). (Unless otherwise specified, all references to Minnesota Statutes are to the 2002 edition.)
[2] Exs. 2-3; Testimony of M.W., Wachlarowicz.
[3] Exs. 2 (entry for Feb. 7, 2003); Ex. 3 (summary of diagnoses).
[4] Testimony of Wachlarowicz.
[5] Testimony of Johnson, M.W.; Ex. 2 (entry for Jan. 27).
[6] Ex. 3.
[7] Ex. 3; Testimony of M.W.
[8] Testimony of Wachlarowicz. It is evident that the Petitioner's behavioral problems are not new. For example, on April 8, 2002, while he was still at Affinia Health Care Center, it was reported that the Petitioner attempted to run over a cognitively impaired resident with his wheelchair. When Affinia staff attempted to redirect the Petitioner, he responded, "They will just have to watch out." Ex. 4.
[9] Ex. 3.
[10] Exs. 2, 3, 12, 13; Testimony of Wachlarowicz.
[11] Ex. 12.
[12] Ex. 3.
[13] Testimony of Johnson; Ex. 3 (entry for Dec. 13, 2002).
[14] Ex. 3.
[15] Ex. 3.
[16] Testimony of Wachlarowicz, Johnson, Rouse, Vandelac, Woode; Exs. 2, 3.
[17] Testimony of Johnson.
[18] Testimony of Vandelac.
[19] Testimony of Rouse.
[20] Testimony of Rouse.
[21] Testimony of Rouse.
[22] Ex. 3 (entries for Oct. 22, 24, and 30, Nov. 6, 19, and 21, Dec. 18 and 26, Jan. 21 and 28, and Feb. 4).
[23] Ex. 3.
[24] Testimony of Wachlarowicz, Johnson, Vandelac.
[25] Exs. 2, 3; Testimony of Vandelac.
[26] Exs. 2, 3; Testimony of Wachlarowicz, Vandelac.
[27] Ex. 2 (entries for Dec. 16, Jan 1, 2, 3 and 29, 2003); Testimony of Wachlarowicz.
[28] Ex. 2.
[29] Ex. 2.
[30] Testimony of Wachlarowicz; Ex. 1.
[31] Testimony of Johnson, Rouse.
[32] Testimony of Wachlarowicz, Johnson, Rouse, Woode; Exs. 1-3 (entries for Dec. 24 and 26 and Jan. 2, 5, 6, 7).
[33] Testimony of Wachlarowicz; Ex. 1.
[34] Testimony of Rouse, Vandelac.
[35] Ex. 2.
[36] Ex. 2.
[37] Testimony of Wachlarowicz, Johnson, Rouse, Woode; Exs. 1-3.
[38] Ex. 2.

[39] Exs. 2, 3, 5; Testimony of Johnson.
[40] Ex. 2.
[41] Exs. 2, 3.
[42] Exs. 2-3.
[43] Testimony of Wachlarowicz, Johnson, Rouse, Woode; Exs. 1-3 (entry for Jan 3, 2003).
[44] Ex. 3; Testimony of Johnson.
[45] Ex. 3.
[46] Ex. 3.
[47] Ex. 3.
[48] Exs. 1-3; Testimony of Wachlarowicz, Johnson, Rouse, Woode.
[49] Ex. 3.
[50] Ex. 2.
[51] Ex. 2.
[52] Testimony of Wachlarowicz, Rouse; Ex. 1.
[53] Testimony of Wachlarowicz, Johnson, Rouse; Exs. 1, 2.
[54] Exs. 2, 3.
[55] Exs. 1-3; Testimony of Wachlarowicz, Johnson, Rouse, Vandelac, Woode.
[56] Ex. 3 (entry for Jan. 29, 2003); Testimony of Woode.
[57] Testimony of Woode.
[58] Testimony of Woode.
[59] Testimony of Johnson, Rouse, Vandelac; Ex. 2 (entry for Feb. 10, 2003).
[60] Ex. 2.
[61] *See* Minn. Stat. §§ 14.50 and 144A.135, as well as sections 1819(e)(3) and 1919(e)(3) of the Social Security Act, codified in 42 U.S.C. §§ 1395-3(e) and 1396r(e).
[62] *See generally* 42 C.F.R. § 483.12.
[63] 42 C.F.R. § 483.12(a)(4).
[64] 42 C.F.R. § 483.12 (a) 6).
[65] 42 C.F.R. § 483.12 (a)(5).
[66] Minn. Stat. § 144A.135(b).
[67] Exhibit 5.
[68] Minn. R. pt. 1400.7300, subp. 5; *In the Matter of the Involuntary Discharge or Transfer of J.S. by Ebeneezer Hall*, 512 N.W.2d 604,610 (Minn. App. 1994).
[69] 42 C.F.R. § 483.12 (a)(2)(i).
[70] 42 C.F.R. § 483.12 (a)(3)(i).
[71] 42 C.F.R. § 483.12(a)(2)(iii) and (iv).
[72] 42 C.F.R. § 483.12(a)(3)(ii).
[73] 42 C.F.R. § 483.12(a)(3).
[74] Minn. Stat. § 14.62, subd. 1.
[75] Section 1919(c) of the Social Security Act Amendments of 1987, Public Law 100-203, codified at 42 U.S.C. § 1396r(c)(2).
[76] *Id*. Other grounds not relevant here are also listed in federal law.
[77] 42 C.F.R. § 483.12. The regulations are identical to the statute, except that reference in 42 C.F.R. § 483.12 (a)(2)(i) is made to "the resident's needs cannot be met" rather than "the resident's welfare cannot be met." Further references in this Memorandum are to the requirements as set forth in 42 C.F.R. § 483.12.
[78] Minn. R. 1400.7300, subp. 5.
[79] In *Ebeneezer Hall*, *supra*, 512 N.W.2d at 610, the Minnesota Court of Appeals confirmed that "a nursing facility proposing to transfer or discharge a resident must prove the supporting facts by a preponderance of the evidence."
[80] *Accord In the Matter of the Denial of Eller Media Company's Applications for Outdoor Advertising Device Permits in the City of Mounds View, Minnesota*, 642 N.W.2d 492, 503 (Minn. App. 2002) (even though DOT did not provide a detailed reason for the denial in its initial denial letter or cite a particular rule until its post-hearing brief, the parties addressed the "spot zoning" issue at the hearing, had the opportunity to present testimony and evidence on that issue, did elicit relevant testimony, and discussed the issue in post-hearing briefs; court held that due process rights to adequate notice were not prejudiced).

[81] 42 C.F.R. § 483.12 (a)(2)(iv).
[82] *Robbins v. Iowa Department of Inspections and Appeals*, 567 N.W.2d 653 (Iowa 1997).